Colleen LaBelle BSN RN-BC CARN
Program Director, Treatment Expansion of Buprenorphine
Bureau of Substance Abuse Services, Boston Medical Center

U. S. Senate Forum
Convened by Senator Carl Levin and Senator Orrin Hatch
Buprenorphine in the treatment of opioid addiction: successes and the Impediments to expanded access
June 18, 2014
SR 222, 9:30am – 1:00pm

In 2002, following enactment of DATA 2000 authored by Senator Carl Levin and Senator Orrin Hatch, Massachusetts hit the ground running in an effort to provide treatment for addiction using buprenorphine/naloxone in office based practices. With FDA approval in 2002, buprenorphine made its way to pharmacy shelves by early 2003, our phones were ringing, patients from all walks of life were searching the internet learning of a potential lifesaving treatment and they wanted it now! We went to our state authority the Bureau of Substance Abuse Services which at that time was headed by Mr. Michael Botticelli and asked if he would sponsor a nurse care manager model with DATA waived physicians in our inner city hospital as a pilot to facilitate access to treatment and provide a level of support and resources to minimize barriers to treatment of this complex disease in busy primary care settings. The demand quickly out paced our ability to treat more patients and within a month we had a growing wait list of patients desperate for treatment. Restricted by the law of 30 patients per federal tax ID we got creative learning we had 3 tax ID numbers within our medical center and tapped in to each one treating 30 patients in each section, however that too was a band aide and again our wait list grew to over 300 people desperate for a medication that was changing the face of addiction, giving patients their lives back, rebuilding families, the difference between life and death. With further legislative changes we were then able to treat 30 patients per provider and by 2006 physician were able to obtain an extended waiver to treat up to 100 patients at a time.

The demand did not stop access was challenging with less than 2% of physicians at this time waivered to prescribe buprenorphine across MA. Again BSAS stepped up and put out a request for proposal across the state to community health centers to

implement models mirrored after BMC with waivered physicians paired with nurse care managers to treat patients with buprenorphine. Physicians at the sites had to be willing to obtain a waiver to prescribe buprenorphine and health centers had to identify a dedicated nurse to be trained and committed to the program that would be monitored and overseen with statewide technical support. BSAS released an additional RFR to provide the training and technical support of the funded community health centers, this was awarded to BMC.

I have been the program director for this statewide expansion of Buprenorphine in the federally funded community health centers since the start up in 2007. When the grant began the bureau funded every applicant that submitted a proposal and has continued to support additional health centers and community settings with training and technical support. This BSAS initiative has allowed for widespread dissemination of treatment in community settings, engaging providers and treating 8,000 since its inception.

We have looked at our Medicaid data of patients in treatment compared to those not in care that are substance users and found that cost decreases when patients are in care. We also took the data that is collected in the 14 funded sites and found that if patients stay in care for 6 months and up to 12months costs go down, emergency room visits decrease, inpatient hospital stays decrease, and expenditures decrease.

Recently I was asked by a patient who is also a social worker, an advocate, a peer leader, and serves as a board member on the bureaus community advisory committee, "how many patients have died in your program while on buprenorphine?' It stopped me in my tracks as I thought through the 11 years of buprenorphine treatment at Boston Medical Center where we treat 450 patients at any given time. I reviewed the data and found deaths from liver cancer, lung cancer, liver failure, renal failure, and cardiac events but not one death from active addiction while in treatment! People die when they are not in care, everyday in MA we lose 2 people a die from an overdose; people don't typically die in care!

Treatment works and that is evidenced by the 2 guests I have with me today Sherri and Ellis both who have stories of addiction and the wrath of destruction and loss it played in their lives, however they are here today because treatment works and buprenorphine has given them a new lease on life.

We all continue to struggle with this public health epidemic and the demand for treatment. Listening to the stories of patients buying and self-maintaining with buprenorphine for 1 and 2 years on the street because they couldn't get in to a program that took their insurance. I was at a parent group on Monday night and they too admitted to buying "suboxone" for their kid on the street. Access remains challenging 11 years later Massachusetts has 5% of physicians waivered to prescribe buprenorphine with half of them serving limited numbers of patients or not accepting insurance. Patients continue to wait for treatment, calling providers listed on resource lists hoping to get lucky and find someone willing to treat them. Why do we treat addiction so differently, why is access to care so challenging? How many diseases do you have to call laundry lists of providers to find one with an open slot, takes your insurance, and is in close proximity to where you live or work? Do you have to call every day, or once a week to keep your name active on a list or risk being removed from the list? We are making patients with a chronic disease that people die from wait for care and jump through hoops that are challenging even for someone who is not a substance user.

Buprenorphine has impacted thousands of lives and changed the way we treat and care for patients with addiction, however we are in the midst of a public health crisis that is killing greater than 100 people a day and we need to do more, we need more treatment, we need evidence based treatment and it needs to be accessible. There is nothing more heart wrenching then picking up the phone to call the next person on the waiting list and hearing the person on the other end of the phone take a big sigh and tell you they died from an overdose! No one should have to wait for treatment needs to be readily available on demand when a patient wants it.